November 29, 2005

Susan Lucas
Health and Recovery Services Administration
Director, Division of Business and Finance
Department of Social and Health Services
PO Box 45500
Olympia, WA 98504-5500

Dear Ms. Lucas,

I am writing on behalf of the Washington State Hospital Association's Medicaid Inpatient Task Force regarding Navigant Consulting's Phase I Report on Medicaid Inpatient Payments. The task force includes the chief executive officers from hospitals that provide the lion's share of Medicaid inpatient service in Washington State.

We commend your agency and Navigant Consulting for conducting a thorough analysis of issues surrounding Medicaid inpatient payments. We generally support the recommendations for further study, but have a number of important issues that need to be addressed as you move forward. These are described in the enclosed three addenda.

Aside from our specific issues in the addenda, we have a major concern about the scope of the study. The task force is concerned about the possibility of making the current system more equitable without additional funds. Pursuant to the legislature's directive, we understand the study is being conducted under an assumption of state budget neutrality. It is impossible, however, to divorce issues of payment distribution from payment adequacy. Hospitals are not currently being paid for the costs of providing care to Medicaid patients. As the Navigant analysis shows, Medicaid inpatient payments in 2004 averaged only 92 percent of the costs of providing care, down from 96 percent in 2002. Similarly, data reported to the Washington State Department of Health show inpatient and outpatient Medicaid payments in 2004 covered only 89 percent of costs.

Simply redistributing payments at current levels will significantly exacerbate the financial difficulties at many hospitals, while only

300 Elliott Avenue West
Suite 300
Seattle, WA 98119-4118
Phone 206-281-7211
Fax 206-283-6122
www.wsha.org

nominally improving the outlook for those on the up side of the redistribution. No industry can sustain negative margins on a significant portion of its business. Hospitals are committed to serving their communities, but need to have adequate payments in order to preserve access to care. It is also critical to our hospitals and the health of our state residents that Washington maintain and enhance eligibility for low income residents.

We look forward to working with you during Phase II.

Sincerely,

C. Scott Bond
Chair, WSHA Medicaid Task Force

Enclosed: Addenda 1, 2 & 3

Cc: Doug Porter, HRSA
Robin Arnold-Williams, DSHS
WSHA Board

ADDENDUM 1

WSHA is providing the following comments on the draft Phase 1 Medicaid Inpatient Payment Report. Hospital members discussed these issues with Navigant Consulting prior to the finalization of the report. Some of these comments may be already addressed directly in Navigant's final revisions.

GENERAL ISSUES

Guiding Principles: The legislature's mandate for this study specifies the objective is "equity among hospitals, access to quality care and improved outcomes for patients, cost control and efficiency for tax payers." The Hospital Association has adopted similar principles, attached as Addendum 3, which we think should guide the state's evaluation of alternatives. It is also important to note that Phase I of this project is preliminary, and the recommendations should only be adopted as a payment system after the work in Phase II is completed.

Payment Adequacy: The report recommends regular updates to the DRG system through periodic rebasing. We believe hospitals on average need to be paid the costs of providing care for Medicaid cases. Payment adequacy must be addressed at each rebasing, rather than simply redistributing an inadequate pool of funds.

Comprehensive vs. Piece-meal Recommendations: The report makes recommendations on a wide variety of specific hospital reimbursement mechanisms. While this may be appropriate for purposes of discussion, hospital reimbursement is a ***system*** in which all the individual mechanisms are integrated and interdependent. As the project proceeds with the Phase II fiscal impact of recommended changes, the recommendations must be evaluated at the system level. Doing otherwise with surely produce unintended results. Any recommendations should be made and adopted as a comprehensive package, and not "cafeteria-style," selecting individual menu items for change.

Importance of Regular Updates: Prospective payment systems are dependent upon regular updates. As the report mentions, updates are needed for distributional factors reflecting evolving clinical practice and utilization (DRG groupers, relative weights). Regular updates are also needed, however, to reflect the increasing costs of providing care. The current system effectively provides updates beyond the vendor rate allowances, since many payments are made outside the prospective system using ratios of costs-to-charges (RCCs). The report recommends minimizing the amount of payment made based on RCCs. If this recommendation is adopted, hospitals must have regular updates that reflect actual increases in their costs of care.

Phase-in for Changes: Whatever changes are ultimately adopted may be appropriate and justifiable in the context of the evaluation criteria, but will likely have dramatic impact on individual hospitals' fiscal viability. Hospitals cannot withstand sudden, dramatic reductions in payment. Any recommendations made should include a phased-in implementation to mitigate the negative impacts and allow hospitals time to adjust their operations accordingly.

Data: As directed by the legislature, the report concentrates on Medicaid inpatient payment. It does not include payments provided in other state-only programs. Readers of the report need to be very careful not to draw conclusions about overall Medicaid payment amounts for hospitals, which reflect both inpatient and outpatient services, or overall state medical assistance payments, which reflect a variety of other programs.

SPECIFIC ISSUES

Per Diems: The reports recommends using per deim payments for services when it is not possible or appropriate to develop a DRG weight. While this may be appropriate for some services, such as psychiatry and rehabilitation, where costs are similar each day, per diems would not be appropriate for acute medical - surgical services.

RCC Payment Methodology: The report recommends moving many inpatient services currently paid using RCCs into the DRG payment system. Given that 32 percent of all payments are made using RCCs, this is probably the most significant change proposed in the report. While we support this general concept, it should be implemented with caution. As discussed below DRGs may not be appropriate for specific hospital types or services.

The report further recommends the state consider using Medicaid-specific, departmental RCCs rather that aggregate all-payer RCCs. We support the use of Medicaid specific RCCs, but question how much additional specificity is beneficial. We can see where an inpatient specific RCC may make sense, but drilling down to individual service units may be too cumbersome or even infeasible for some hospitals.

Stability of DRG Relative Weights: A DRG payment system depends upon sufficient and statistically consistent data to establish "average" payments for given DRGs. DRG payments based on low volumes or widely varying experience may harm hospitals that provide these services. An example is neonatal care, where a limited set of DRGs represent a wide range of complexity of care. In these cases, average DRG payments, even with outlier provisions, may not appropriately pay hospitals. In evaluating the impact of changes to the DRG system, consideration must be given to the impact on sensitive services within each hospital.

New Technologies: We support the recommendation to update the system to the most recent version of the AP-DRG grouper and to regularly update it as new versions are released. Regular updates still rely on historical costs that will be several years old. With the speed of advances in medicine, however, even regular updates will not adequately reflect the newest, often costliest technologies. We recommend consideration be given to implementing a "pass through" payment method for new technologies, until such time as their costs can be adequately reflected in prospective payments.

DRG Conversion Factors: The report recommends the state consider using statewide conversion factors with adjustments for cost variations such as regional wage differences, graduate medical education, trauma care capacity, or specialized services capacity. We agree that this approach can produce an equitable, efficient DRG system, but the development of adjustment factors should be conducted with very careful consideration of the impacts. We further believe that uncompensated care volume needs to be considered as a variable for adjusting statewide conversion factors.

Specialized Hospitals: Certain types of hospitals may specialize in services for which a DRG system based on a more general experience may not provide appropriate payment. For this reason Medicare uses separate prospective payment systems for acute care hospitals, long term care hospitals, rehabilitation hospitals, and psychiatric hospitals, and exempts children's hospitals and cancer hospitals from prospective payment. The final recommendations of this Medicaid study need to evaluate the impact of a single DRG system on these hospitals and consider alternatives to ensure appropriate payments.

Outliers: The report recommends revising the outlier policy to reduce the percentage of outlier payments relative to total payments. While we agree with this recommendation, we urge caution in evaluating the impact on certain facilities. For several hospitals, cases that reach outlier status make up a disproportionately high percentage of their patient population. For these hospitals, the large number of outliers is due to their role as regional providers, and not due to outdated outlier thresholds. Particularly if the state adopts state-wide DRG conversion factors, care should be taken to avoid redistributing "true" outlier payments from these facilities to increased inlier payments to all hospitals.

Utilization Review Under Per Diem Reimbursement: The report recommends switching from RCC reimbursement to per diem reimbursement wherever appropriate. The recommendation further includes implementation of a presumably new concurrent utilization review process. We question the perceived need for a new review process given that the current RCC methodology includes a utilization review component. We are concerned that a new process will add administrative cost and complexity for the hospitals and the state and will reduce the amount of resources available for delivery of health care.

Critical Access Hospitals: The report recommends a single cost settlement using hospitals' finalized cost reports. This recommendation is generally reasonable. Due to the twelve to eighteen month lag between hospital fiscal year end and cost report finalization, however, we strongly recommend the state develop a process to allow hospitals to request mid-year adjustments to interim rates based on updated cost information. This will ensure interim rates reflect actual costs as accurately as possible, and minimize receivables and payables at cost settlement.

Psychiatric Services: The report suggests the development of a fee-for-service payment system for psychiatric hospitals can be deferred to a later date, because the state is moving toward an increased degree of managed care responsibility for hospital services by Regional Support Networks (RSNs). We feel strongly that the state should proceed with evaluating payment for psychiatric services during Phase II of the project. First, under Medicaid managed care programs, it is common for payers to use the state's Medicaid fee-for-service rates in their contracts with providers. There is only a short time period for the RSN's to assume responsibility for inpatient hospital contract administration, and the RSNs will need to have fee-for-service rates to facilitate the transition. Second, as hospitals enter into contract negotiations with the RSNs or other managed care organizations, they need to know what the appropriate payment is under the Medicaid fee-for-service program.

Trauma: The report recommends the state conduct a study to examine the costs of maintaining trauma capacity. We believe this duplicates work already being performed by the Department of Health Trauma Technical Advisory Group and strongly recommend it remains within this purvue.

Border Area Hospitals: The report recommends paying border area hospitals not necessary for access at the average rate paid to Washington hospitals. This may actually increase payment to some out-of-state hospitals and disadvantage their cross-border Washington counterparts. We recommend the state adopt a payment system that minimizes the flow of payments to non-Washington hospitals. One suggestion would be to adopt a policy of paying the lesser of the Washington state average, the border-area hospital's home state Medicaid rate, or the out-of-state's payment rates for Washington hospitals.

ADDENDUM 2 - "OUT OF SCOPE" ISSUES

Hospital finances are complex, comprised of several varied, yet interrelated factors. Evaluating and modifying one specific component, Medicaid inpatient reimbursement, may make sense in isolation, but may have unintended impact on overall hospital finances. While recognizing the limitations of this study's scope, it is important that Navigant and the legislature consider any recommendations in the context of the following other issues.

Inpatient Versus Outpatient: The Legislature mandated the study examine inpatient reimbursement only. In doing so, Navigant has examined aggregate and individual hospital inpatient payments relative to costs. In order to estimate hospital inpatient costs Navigant uses aggregate ratios of cost-to-charges (RCCs) that are calculated as a weighted average of both inpatient and outpatient experience. Typically, inpatient-only RCCs are higher than outpatient-only RCCs, resulting in blended RCCs somewhere between the two. Applying the blended RCCs to inpatient charges will tend to underestimate inpatient costs, and present an overly favorable picture of payments relative to costs.

Any presentation of inpatient payments relative to inpatient costs may likely be misconstrued to represent overall payments relative to overall costs— again presenting an overly favorable picture and not correctly representing overall payment adequacy. Outpatient payment is typically much lower relative to costs. Data on inpatient payments relative to costs overstates the adequacy of payments for overall costs.

Disproportionate Share Hospital Payments: Disproportionate Share Hospital (DSH) payments are another integral component of hospital reimbursement deemed out of scope for the Navigant study. Again, however, these need to be considered in any evaluation of inpatient reimbursement. Medicaid DSH payments are intended to offset the acknowledged inadequacy of Medicaid payments, as well as the losses incurred by hospitals through the delivery of charity care. One of the Medicaid inpatient payment principles endorsed by the hospitals is that rates should reflect uncompensated care. Medicare inpatient rates, for example, include an adjustment to all DRG payments to reflect uncompensated care provided to Medicaid and uninsured patients. We think the report needs to consider whether an adjustment to rates is needed for Medicaid, in addition to the DSH payments.

In many cases hospitals' eligibility to receive supplemental payments under Medicaid DSH programs may be limited by federal rules. For example, rural hospitals which are unable to offer obstetric services due to lack of physician coverage do not qualify for Medicaid DSH. Similarly freestanding psychiatric hospitals determined to be institutions of mental disease are limited in how much DSH they can receive by federal rules restricting Medicaid eligibility for their patients and state policies allocating the vast majority of allowable DSH to the two state psychiatric hospitals.

Critical Access Hospitals: Critical access hospitals are, by definition vital to the provision of health care in their communities. In many cases they provide not only inpatient and outpatient services, but also primary care clinics, long term care, home health, or other services. Reimbursement for many of these services, particularly long term care, is well below cost. In fact, cost allocation rules require CAHs to allocate hospital costs that could otherwise be

reimbursed under Medicare and Medicaid to sub-units paid at rates significantly below cost. Cost-based reimbursement for inpatient and outpatient services sustains not only access to hospital services, but access to overall health care in rural communities.

State Mental Health System : A study cannot look at payment for inpatient psychiatric services without examining the condition of the state's system of delivering mental health treatment. State policy decisions have resulted in a system that places an undue financial burden on not only those hospitals that provide acute inpatient mental health services, but also on all hospital's emergency departments, which are becoming the de-facto mental health facilities for the state. Bed closures at the state hospitals increase the demand for limited community hospital mental health bed capacity, backing patients up in emergency departments. Lack of residential treatment options delay discharge of patients and increase losses under discounted DRG-based state-only programs. Cuts in Regional Support Network funding are leading the networks to deny authorization for inpatient admissions. This increases hospitals' uncompensated care and decreases patient revenues necessary to offset fixed costs. In conditions of fiscal strain, mental health services are among the first considered for elimination by hospitals trying to balance their finances.

Physician Payment: Clearly outside of Navigant's scope of work, but not unrelated is the impact of low Medicaid physician payment on access to physician services, and consequently on hospitals where emergency departments are increasingly picking up the slack. As physicians close their practices to Medicaid patients in response to poor payment rates, hospitals are either employing physicians and, therefore, incurring the losses the physicians are trying to avoid or, more frequently, are treating non-emergent cases, often at a financial loss, in emergency departments.

Cost Shift to the Private Sector: Related to the overall adequacy of payment is concern over the shifting of costs unpaid by government payers (Medicare and Medicaid) to commercial insurers and businesses in the private sector. As government payment fails to keep pace with hospital costs, hospitals must increasingly rely on margins from private payers to offset the losses on the public side. This is a factor in the rate of health care inflation being experienced by Washington businesses, and amounts to an implicit tax on employers that provide health insurance for their employees.

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ADDENDUM 3

Principles for Medicaid Payments to Washington Hospitals

1. On average, Medicaid payments to hospitals should reflect the cost of treating Medicaid patients. In Washington State, hospitals are not currently recovering their Medicaid costs. ***Implication:*** *Additional funding is needed.*

2. Medicaid hospital payments should promote efficiency and reward clinical excellence. The system should not simply pay whatever costs a hospital incurs, without regard to costs unrelated to the efficient delivery of quality care. Efficient hospitals should be rewarded as well as those with improved patient outcomes. ***Implication:*** *Medicaid payments should be determined based on average costs for similar cases in similar hospitals. Medicaid payments should provide positive incentives for improved outcomes.*

3. Medicaid payments should recognize differential costs that are beyond the control of individual hospitals (for example, case mix, acuity, and area wage differences). ***Implication:*** *Several adjustment factors are required.*

4. Medicaid payments should recognize the additional costs, both direct and indirect, incurred by teaching hospitals. ***Implication:*** *Teaching costs should be paid separately from operations on a facility specific basis.*

5. The Medicaid payment system should recognize the cost of uncompensated care. ***Implication:*** *Medicaid should pay higher payments to those hospitals with large charity care costs.*

6. The Medicaid payment system needs to recognize the special needs of small and critical access hospitals. *Implication: Small and critical access hospitals need to be paid based on their costs for providing care.*

7. Hospitals cannot withstand sudden, large reductions in revenue. ***Implication:*** *If a new system produces large shifts in payments, it should be phased in over time.*

8. The payment system needs to be simple to administer and needs to be updated frequently. ***Implication:*** *The system needs to be rebased as soon as possible. The contracting system, which makes rate setting more complex for hospitals and the state, should be eliminated.*

9. The system should use federal dollars to support Medicaid and low income patients. ***Implication:*** *Whenever possible and appropriate, the state should use federal dollars and develop programs such as disproportionate share hospital and upper payment programs, as long as individual hospitals are not harmed financially.*

10. Washington State should concentrate its funds on in-state hospitals and not overpay hospitals outside the state. ***Implication:*** *Out-of-state border hospitals should be paid at lower rates (either based on a method that pays the lower of the Washington rate or their own state's rate, or on some other reduced payment method).*

300 Elliott Avenue West
Suite 300
Seattle, WA 98119-4118
Phone 206-281-7211
Fax 206-283-6122
www.wsha.org

Claudia Sanders/Randy Revelle
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